NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

May 4, 2012

Toby Douglas, Director
California Department of Health Care Services
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Delivered via e-mail to: info@CalDuals.org

Re: Comments on draft proposal for California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals

Dear Director Douglas,

Thank you for providing this opportunity to comment on the draft proposal for California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals. The National Senior Citizens Law Center has been an active participant in the dual eligible demonstration stakeholder process. We participated in the 1115 dual eligible technical workgroup, served on the Dual Eligible Technical Assistance Panel, currently co-lead a stakeholder workgroup on beneficiary enrollment, notification and appeals and have been involved in numerous meetings and conversations with Department staff and contractors.

We support the goals of the Demonstration and have had high hopes that the Department of Health Care Services would use the opportunity presented by the Demonstration to develop innovative, person-centered systems of care that would simplify the existing system and improve access to care for dual eligibles.

Unfortunately, we do not believe that this proposal will accomplish these goals. We have concerns about the following components of the plan. Our comments below and the attached comment chart provide more detail about our concerns.

1. **Implementation Schedule:** The proposal lacks detail on a number of important elements including: rate setting, readiness and network adequacy standards, appeals system design, assessment tool, beneficiary notices, evaluation criteria and more. Time is running out to finalize these details before the demonstration is slated for implementation. The Department proposed an implementation schedule that will force the state and stakeholders to rush these important policy decisions. It will also not provide enough time to properly notify beneficiaries of these immense changes or to expand existing medical networks and develop new long term services and supports networks.

Recommendation: Finalize important details like appeals processes, network adequacy standards and the uniform assessment tool before implementing the demonstration.

Recommendation: Join the growing list of states that are pushing implementation back to 2014 and implement the four county demonstration over a two year period.

2. **Enrollment Process:** The Department proposes mandatorily enrolling dual eligibles into Medi-Cal managed care, passively enrolling them into the demonstration and then locking them into plans even if when the plan is not meeting their needs. This enrollment process represents a significant weakening of consumer protections and cannot be justified as necessary to complete the goals of this project.

   Recommendation: Opt-in enrollment is the most appropriate enrollment vehicle for any demonstration. Leaving one's established care delivery network to participate in an experiment should be an entirely voluntary choice.

3. **LTSS Integration**: The Department proposes integrating long term services and supports as part of the demonstration. We support the goal of integrating LTSS in order to maximize the ability of dual eligibles to remain in their homes and communities. More details and consumer protections are necessary,however, to ensure that the demonstration leads to greater, not worse, access to home and community based services.

   Recommendation: Add additional consumer protections to ensure that access to home and community based services is improved under the demonstration.

4. **Plan and Site Selection:** The fact that the Department has selected several plans that have poor quality ratings in the Medicare and Medi-Cal programs is a major concern. We are particularly worried about the two plans that have below average ratings in the Medicare program and the one plan that has a recent history of significant Medicare enrollment and marketing sanctions. We are also concerned that the plans selected are currently serving too small a number of dual eligibles to take on the increased enrollment targeted by this proposal.

   Recommendation: Select only plans with strong performance records in both Medicare and Medi-Cal. Do not allow plans with below average Medicare quality ratings or plans with a recent history of sanctions in the Medicare program to participate.

   Los Angeles County, in particular, is not an appropriate place to launch such a complicated and difficult demonstration. The dual eligible population is larger and more diverse in Los Angeles County than any other in the nation. The plans that were selected in Los Angeles County have poor performance records in the Medicare and Medi-Cal programs and are currently serving just 7,500 of the County's 373,000 dual eligibles.

Recommendation: Select counties of a manageable size with quality, experienced plans. Do not include Los Angeles County in the demonstration. If Los Angeles County is included, prohibit the selected plans from utilizing passive enrollment.

5. **Number of counties:** The proposal includes expansion of the number of counties participating in the demonstration beyond the originally authorized four. There are not more than four counties with high quality plans ready to implement the demonstration. Including more counties, plans and beneficiaries will make the demonstration more difficult to prepare for, explain to the community and oversee and monitor. If the goals of the demonstration are not met, it will be harder to make adjustments or reverse course.

   Recommendation: Focus the demonstration on no more than four counties that have demonstrated the capacity to take on this difficult task. Wait to learn from those counties before expanding.

6. **Beneficiary Protections and Improvements:** The proposal does not include many new protections nor guarantee any new benefits or services for dual eligibles. The care coordination it offers is already available to dual eligibles through existing Medi-Cal and Medicare managed care organizations and, for some, through home and community based services like CBAS and MSSP. Other potential benefits the proposal purports to offer - for example, dental and vision benefits the state has cut in recent years and expanded access to home and community based services - are theoretical and contingent upon financing. The proposal must guarantee that beneficiaries will get something they cannot get now.

   Recommendation: Require the inclusion of additional benefits like dental and vision in the plan benefit packages. Create specific requirements related to the enhanced provision of home and community based services.

Thank you for the opportunity to submit these comments. Please let us know if you have and questions or would like to discuss our comments further.

Sincerely,

Kevin Prindiville
Deputy Director

Georgia Burke
Directing Attorney

EXPANDED COMMENTS ON MAJOR ISSUES OF CONCERN

1. IMPLEMENTATION SCHEDULE

The Department is proposing to start the notice process to beneficiaries in October 2012 and to begin enrollment in January 2013. Passive enrollment would be phased in based on birth month.

We oppose the timetable as unrealistic and unsafe for dual eligibles.

As the Department is well aware, most of the details of the demonstrations are still being decided. They include such critical items as:

- Rate setting
- Readiness and network adequacy standards
- Care Coordination Standards
- Uniform assessment tools
- Appeals system design
- Beneficiary notices
- Evaluation criteria
- Enrollment procedures, disenrollment, marketing rules and more.

In light of their complexity, the need for stakeholder input and CMS consultation, none of the designs for these elements are likely to be in place until late summer or early fall. All must be operationalized by January 1, and enrollment procedures need to be operationalized by October 1.

Our first concern is that the forced speed of the design phase will lead to poor policy decisions. Merging elements within Medi-Cal that have operated separately is itself a huge undertaking. Merging Medicare and Medi-Cal in addition is doubly challenging. Though the Department has set up workgroups for some of the biggest issues, the compressed timeframe does not allow for as much detailed analysis as is needed. Errors on the front end can lead to serious disruptions in implementation.

Our second concern is implementation. Each element must be operationalized, which involves coordinating data systems, setting up new procedures and protocols, training, scripts, notices, etc. To be done right, these all take more time than the three or four month window between finalizing contracts and going "live."

Plan provider networks need to be developed. In Los Angeles County, for example, the chosen plans currently provide Medicare benefits to only 7,492 (2%) of the County's duals. Together they will enroll as many as 30,000 duals each month under the demonstration. The growth needed in providers with expertise to serve the chronic conditions and special needs of duals is substantial. And simply signing up more providers is only the start. If the demonstrations are to fulfill their promise, new providers need to be trained in the care coordination protocols of the

plan, and systems need to be in place for the sharing of records, collecting encounter and evaluation data. Making all this happen with a large number of new providers again takes more time to do right than the current schedule would allow.

The appeals system is another example. A coordinated appeals system has not yet been designed. Yet by January 1, that system needs to be operational. Procedures must be devised to implement the new systems; beneficiary explanations of procedures need to be written; procedure manuals for internal and external decision-makers need to be developed; model notices must be written; and most importantly, reviewers need to be trained in how to apply both Medicare and Medicaid standards to any claim.

We also have serious concerns that the relentless pace of the demonstration will lead to shortcuts in readiness reviews. There will be pressures from many fronts to provisionally approve plans, proceed even if data systems have not been fully tested and otherwise cut corners in order to start enrollment on schedule. The experience with the transition to Medicare Part D in January 2006 provided a vivid lesson in the harm to beneficiaries when they are thrust into a system that is not ready to meet their needs. The risks to beneficiaries are simply too high to justify a race to meet an artificially imposed deadline.

As importantly, beneficiaries and the community need to be educated and prepared for the demonstration. Under the proposed timetable, it will be impossible to provide the needed groundwork with providers, beneficiaries and their families, community organizations and the public at large so that they can understand the significant changes that the demonstrations will represent. It will be difficult and will take time to prepare clear beneficiary notices in multiple formats and languages within the proposed timetables – an essential task given the diversity and need for alternative formats in this population.

We also have serious concerns that the timetable in inadequate for the training that will be needed for the many players who will be involved in assisting beneficiaries through the process, including but not limited to enrollment brokers, choice counselors, current providers to beneficiaries, state, federal and plan CSRs and many other parties.

The need to properly lay the groundwork in the community and particularly the provider community cannot be overstated. Advocates are already hearing from beneficiaries that their doctors are saying that they will no longer be able to treat the beneficiary if the beneficiary is in managed care. This is causing confusion and distress among beneficiaries. The providers are acting in many cases out of misinformation or, at least, lack of information. One lesson from the SPD enrollment experience and from the move of CBAS to managed care has been that significant time and effort are needed to prepare providers and beneficiaries for a significant change. Many of the problems that SPD beneficiaries have had in transitioning to the new system have arisen because, despite transition policies, their current providers have been fearful, misinformed or simply so wary of the new system that they refuse to continue treatment. The lead time for informing providers in the SPD program was 9 months and that was insufficient.

The problem is repeating itself with the CBAS program. Currently many CBAS enrollees are telling advocates that they fear they will have to leave the CBAS program because their Medicare providers are telling them that they are unwilling to be part of managed care, even though in fact, those providers do not need to join a managed care plan in order to continue to provide Medicare services to their patients. This is discussed in more detail below.

Without effective outreach to providers about the duals demonstration, the problems encountered in the SPD and CBAS transitions are likely to be magnified in the demonstrations, which are broader in scope and impact. As the SPD experience shows, such outreach takes time and effort. Yet dual eligibles will be receiving letters about their choices starting in October and will be looking for advice from their providers then. Since the full contours of the demonstration will not be available until late summer or early fall, it simply is not possible to get accurate information into the hands of diverse and independent providers, answer their questions and ensure an understanding of the demonstration's parameters.

> **Recommendation:** Join the growing list of states that are pushing implementation back to 2014 and implement the four county demonstration over a two year period.
>
> **Recommendation:** Finalize important details like appeals processes, network adequacy standards and the uniform assessment tool before implementing the demonstration.

2. ENROLLMENT

The proposed enrollment process does not pass the test of creating a simpler system that includes strong consumer protections and will be easier for beneficiaries to understand and navigate. Instead, the proposal weakens current consumer protections and introduces new complexity and confusion to the system. As a result, beneficiaries risk losing access to current Medicare and Medi-Cal providers and services.

The Department is proposing to change both the Medicare and Medi-Cal enrollment rights of dual eligibles in several significant ways. It currently has state legislative authority to make some of these changes, but not others. All of the proposed changes would require new federal authority. The various layers of the proposed enrollment process and the fact that the proposed policies have not yet been authorized by the Legislature makes the proposal difficult to comment on and nearly impossible to explain to community based organizations and providers, not to mention individual dual eligibles. Misinformation about the enrollment process is already spreading through the community. Below are comments on each distinct change to the enrollment system.

Mandatory Medi-Cal Managed Care Enrollment

The Governor's Coordinated Care Initiative (CCI), which is pending before the state Legislature and will likely not be acted upon before submission of this proposal to CMS, proposes requiring all dual eligibles to enroll in a Medi-Cal managed care plan to receive their Medi-Cal benefits. Dual eligibles in the demonstration counties would be included, but so would dual eligibles in all

other Medi-Cal managed care counties. Currently, dual eligibles in County Organized Health System counties are required to enroll in Medi-Cal managed care, but those in Two-Plan and Geographic Managed Care counties are not. The Department does not have authority from the state Legislature or CMS to expand mandatory managed care enrollment to all Two-Plan and GMC counties. The proposal does not specify what authority would be sought to get approval for this change from CMS or when.

When the Department developed its 1115 Bridge to Reform Waiver less than two years ago, it could have requested authority to mandatorily enroll dual eligibles in all managed care counties into Medi-Cal managed care. It wisely refrained from doing so. For dual eligibles, Medicare is the primary payer for most services. Medicaid wraps around the Medicare benefits providing additional coverage of long term services and supports.

A managed care plan responsible for only the Medi-Cal benefits will have little incentive or ability to manage the care of the individual since most of the medical care is being provided by another program and payer (Medicare). There is, however, a serious risk that access to Medicare providers and services will be impeded. We are seeing this dynamic play out now in the transition of dually eligible CBAS recipients into Medi-Cal managed care plans. As stated above, beneficiaries are being told by their Medicare providers that they will refuse to continue to see patients that enroll in a Medi-Cal managed care plan. The Department has indicated to CBAS providers that there is nothing they can do about this problem. In addition, some plans have told beneficiaries that they need to select a new primary care physician that is a member of the Medi-Cal managed care plan network, even though it is Medicare that will be the primary payer for services provided.

We oppose the Department's proposal to mandatorily enroll duals eligibles into Medi-Cal managed care in Two-Plan and GMC counties.

Passive Enrollment into the Demonstration Plan

In addition to requiring dual eligibles to enroll in managed care plans to receive Medi-Cal benefits, the Department proposes passively enrolling dual eligibles into those same plans to receive their Medicare benefits.

Under current law, dual eligibles, like other Medicare beneficiaries, have to right to choose their own providers. Since Medicare managed care plans restrict beneficiary choice to a network of contracted providers, in almost all cases, Medicare beneficiaries are defaulted into Original or Fee for Service Medicare where their freedom of choice rights are preserved to the full extent. With limited exceptions, Medicare beneficiaries must actively choose to enroll in a Medicare managed care plan.

The proposal would change the default enrollment for dual eligibles from FFS Medicare to a private managed care plan. The accompanying restrictions on provider access represent a weakening of a key consumer protection – freedom of choice of providers. As a result, many

beneficiaries will lose access to current Medicare providers and will have fewer options for Medicare providers than they have now.

We oppose the Department's passive enrollment proposal.

Lock-In Enrollment

Going even a step further, the Department would require individuals that enroll in a plan, either by their own choice or through the passive enrollment process, to receive their Medicare benefits from the plan for 6 months.

This proposal goes beyond MMCO's 'preferred enrollment' standard and represents a significant weakening of current consumer protections. In recognition that dual eligibles are a particularly vulnerable population with changing health needs that may require a disenrollment from a Medicare prescription drug or managed care plan that is not able to meet those needs, dual eligibles can currently change plans at any time. Even non-Medicaid eligible Medicare recipients have the right to disenroll from a Medicare Advantage plan during the first 45 days of a new plan year. The Department's lock-in proposal would leave dual eligibles with less protection then they have now and less protection than other Medicare beneficiaries have.

The lock-in proposal is particularly problematic when combined with a passive enrollment process. Many dual eligibles will end up enrolled in plans by default since the affirmative selection rate for this population is historically low. For these dual eligibles, by the time they realize they have been enrolled in a plan and understand the impact the enrollment will have on their access to providers and services, they will be stuck in the plan.

If the lock-in period were ultimately pursued, many questions about how the lock-in enrollment period would work in the context of a phased enrollment process and current Medicare enrollment periods would need to be addressed.

We oppose the Department's lock-in proposal.

D-SNP Enrollment and PACE

While not discussed in the proposal, the Department recently released guidance for existing Dual Eligible Special Needs Plans. Under the guidance, D-SNP's in the demonstration counties will be encouraged to contract with the Demonstration Plan to meet MIPPA requirements. These contracts may or may not include requirements for the D-SNP to provide Medi-Cal covered services including LTSS. If a contract is signed, enrollees in the D-SNP will not be subject to passive enrollment into the duals demonstration.

While we do not have a particular proposal for how to handle existing D-SNPs, we note that the current guidance only creates a more complicated set of enrollment options and possibilities that will be extremely difficult to explain to beneficiaries and those that serve them. It will also be extremely difficult to monitor the quality of services provided under these subcontracts. The

Department's inability to spot this issue earlier and design an easy to understand policy to address it, raises serious concerns about whether it has the resources and expertise necessary to implement this proposal properly.

The draft indicates that PACE would remain an option, but fails to recognize the impact an "opt-out" model would have on PACE enrollment. Without an independent assessment and screening tool done in conjunction with enrollment, there is a risk that this proposal could harm California's (and the nation's) most successful model for integration.

Insufficient Enrollment Protections

To address some of the concerns above, the Department offers a care continuity provision which would allow individuals to continue to see current Medicare providers for up to 6 months, even if those providers are not part of a plan's network. While very important, the proposed care continuity provision is an insufficient protection for a passive enrollment model as it relies on a provider's willingness to accept payment from the demonstration plan. The CBAS and SPD transitions have made clear that many providers are unwilling to continue seeing patients once they have enrolled in a managed care plan. The Department is aware of this problem and there is nothing in the proposal that will remedy it. The care continuity provision included is very similar to the one which is exists and, according to reports from the field, has not been effective in the SPD process.

We do not fully understand the providers' reluctance to accept payment or enter into contracts with the managed care plans, but we expect that it is based in part on concerns about rates and administrative complexities. Regardless of whether these concerns are valid, it is the beneficiary who will suffer. An alternative approach would be to allow the out-of-network provider to continue to receive payments directly from Medicare and Medi-Cal during a transition period.

The Department also commits to designing and implementing an enrollment process that provides seamless transitions with no disruptions in care. While we agree with that goal, we note the lack of details provided at this point as to how this would be achieved. We also note the short timeframe available to develop a successful process for transitioning such a large number of beneficiaries, especially in a county as large, diverse and complex as Los Angeles.

Finally, the proposal indicates that plans may partner and contract with local advocacy organizations, providers and case managers to assist with outreach and enrollment activities. While the need for local advocacy organizations, providers and case managers to assist beneficiaries in understanding their enrollment choices is clear, support for this work must not come in the form of direct contracts with plans where incentives will exist to enroll individuals into the demonstration even if the enrollment would not be in their best interest. Consumer assistance must be both conflict-of-interest free and funded. If plans are funding the assistance, the money should be administered by an independent entity and without any targets or incentives for enrollment.

Medicare Advantage plans, including some of the plans selected to participate in the demonstration, repeatedly violated and exploited Medicare marketing rules during the years following the creation of the Medicare Advantage program. The demonstration must not weaken important protections which were created to protect dual eligibles from these abuses.

In addition to providing enrollment assistance, the proposal must include a plan for developing a dedicated, independent Ombudsman to monitor the enrollment process and ongoing performance of the plans. The Ombudsman must have expertise in Medi-Cal, Medicare and long term services and supports. The Ombudsman will be most effective at assisting individuals and identifying systemic problems if it is housed in a strong advocacy organization with a history of advocating for this population. In Wisconsin, which is often held out as a successful model for managed integrated care, Disability Rights Wisconsin receives funding to serve as the Ombudsman. We recommend a similar approach, utilizing Disability Rights California and the Health Consumer Alliance.

Beneficiary Reaction to the Proposed Enrollment Process

It is important to note that there has been limited, if any, beneficiary support for the enrollment process the Department has outlined. Even when the proposal was limited to a passive enrollment with full and open opt-out rights, beneficiaries objected. When the Department surprised stakeholders by including a lock-in proposal in a draft document in January, opposition to the enrollment model specifically and the proposal generally escalated significantly.

The reaction of beneficiaries may be based in part on the Department's continued inability to explain how the proposed enrollment process represents an increased consumer protection. The Department claims that passive enrollment with a lock-in is necessary "to ensure a sufficient volume of enrollees over the demonstration period," but has failed to define publicly what "sufficient volume" would be. As mentioned above, the two plans selected to serve as demonstration sites in Los Angeles County currently serve, collectively, about 7,500 dual eligibles in their D-SNPs. There are over 370,000 dual eligibles in Los Angeles County. How many of these dual eligibles would need to enroll in the demonstration to make it successful and sustainable? How many new enrollees could these plans realistically absorb over a year? In San Mateo County, nearly 60% of all dual eligibles in the County are already enrolled in the health plan. How many more are needed to have a sustainable model?

The Department has also asserted that the lock-in is necessary to "encourage beneficiaries to establish a relationship with a plan and providers, so beneficiaries can adequately evaluate this care model." In meetings, the Department has framed the issue differently, asserting that plans need the lock-in to be properly incentivized to provide good care. The implication is that if beneficiaries have the opportunity to opt-out of the demonstration or change plans at any time, they will do so frequently, making it impossible for a plan to prepare to meet the needs of the population. But again the Department provides no evidence to support this implication. Experience in Medicare Part D, Medicare Advantage and PACE indicates that this population does not opt-out of or change plans at a high rate. Nationally, disenrollment rates for PACE (a

completely voluntary program that beneficiaries can leave at anytime) are just 5%.[1] Disenrollment rates for non-Private Fee For Service Medicare plans are below 9%.[2] When individuals do disenroll from Medicare managed care plans they do so because of problems accessing providers and services or because they were misled into joining the plan in the first place.[3] It is in the best interest of the state, CMS and beneficiaries that they have the right to leave a plan that is not working for them. Plans that provide quality services do not and will not struggle to retain enrollees.

> **Recommendation:** Use a truly voluntary "Op-In" process for both Medicare and Medi-Cal benefits; including the right to disenroll at anytime.

We have repeatedly indicated our desire for a truly voluntary, opt-in enrollment process. Such a system would honor the autonomy, independence and choice of the individual. A voluntary enrollment process for Medicare benefits preserves for low-income dual eligibles the same right to provider and delivery system choice that exists for middle and higher income Medicare beneficiaries. Preserving that choice is key to maintaining continued access to specialists and other providers that may not participate in the integrated model, particularly for those with complex medical conditions. Maintaining a voluntary Medi-Cal managed care process in the Two Plan and GMC counties allows beneficiaries to avoid disruptions to Medicare provider relationships that may occur as a result of the Medi-Cal managed care enrollment.

Voluntary, "opt in" enrollment processes have been used by integration models that are generally regarded as positive, beneficiary-centered programs. For example, the Program for All-Inclusive Care for the Elderly (PACE) is an "opt in" model. Massachusetts' Senior Care Options, Minnesota's Senior Health Options and Wisconsin's Family Care Partnerships all use an "opt in" enrollment model. An "opt-in" enrollment mechanism ensures that participating plans attract and retain enrollees by offering each enrollee a higher quality, more coordinated experience than the one they have in the fee-for-service system. The "opt in" model also ensures that program participants are committed and willing to use the care coordination services that the model is designed to provide.

Opt-in enrollment is the most appropriate enrollment vehicle for any demonstration. Leaving one's established care delivery network, however imperfect, to participate in an experiment should be an entirely voluntary choice.

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[1] MedPAC analysis of 2009 data from the MBD/CMS Medicare Entitlement File, 2009 Medicare Denominator File. http://www.medpac.gov/transcripts/Duals%20presentation_Public%20slides_final.pdf

[2] Government Accountability Office, Characteristics, "Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans," December 2008. http://www.gao.gov/new.items/d0925.pdf

[3] Medicare Rights Center, "Why Consumers Disenroll from Medicare Private Health Plans," Summer 2010. http://www.medicarerights.org/pdf/Why-Consumers-Disenroll-from-MA.pdf

3. LTSS Integration

We support the proposal to integrate long term services and supports into the demonstration in an effort to improve access to and delivery of home and community based services. The process of integrating LTSS is difficult and complex and must be undertaken with great care to ensure compliance with the Americans with Disabilities Act and *Olmstead*. Additional details and protections must be added to the proposal to ensure that beneficiaries are properly protected.

IHSS Integration

We are heartened by much of the language in the proposal and the Department's proposed trailer bill, including that IHSS consumers will retain the ability to "select, engage, direct, supervise, schedule, and terminate IHSS providers" and that processes for assessing and approving hours will be based on current statutory authority. However, we are concerned that the administration's proposal stops short of guaranteeing the preservation self-directing IHSS. Here are some of our major concerns:

The purpose of maximum inclusion and integration is not yet a meaningful part of the managed care plan's obligations. The Department relies on the idea of inclusion of all long term care into a single capitated rate as providing sufficient incentive for plans to provide IHSS and other home and community based services, which are generally much less expensive than nursing home or hospital care. To the extent that IHSS serves to prevent unnecessary hospitalizations and nursing home stays, we agree. However, IHSS does not exist merely to prevent hospitalization. It also serves the purpose of allowing independent living in the most integrated setting possible. The Department has not shown how it will require plans to take into account this value when calculating their bottom line. In fact, plans who are paid a single capitated rate for all LTSS will have an incentive to keep hours as low as possible, so long as the resulting deterioration in the consumer's condition stops short of hospitalization or nursing home care. While the administration claims it will prevent this by refusing to allow plans to cut existing IHSS hours, it has not explained how it will ensure that plans' incentives to cut costs do not gradually erode the availability of IHSS and its support for independent living, especially for new consumers.

Second, the proposal does not explain how it will ensure that managed care plans have the necessary expertise to play a meaningful and appropriate role in IHSS needs assessment and coordination of care. For consumers whose care coordination needs are very high, a great deal of expertise and care coordinator direct involvement is required, often in social or non-medical arenas outside the competence of mainstream managed care plans. Research shows that existing successful models of managed care for dual eligibles with integrated LTSS rely on strong ties to the local community, have extensive experience dealing with particular populations of duals, and evolve slowly and gradually over time. These qualities are not easily replicated by the vast majority of the plans that have been selected. Meanwhile, consumers who self-direct IHSS independently may find their autonomy undermined if a plan becomes involved in either care coordination or assessment in any substantial capacity.

Third, the Department has not guaranteed that consumers' rights will be preserved. For

instance, the Department's trailer bill states that IHSS would still be subject to "a grievance and appeal process," but it falls short of explicitly guaranteeing that consumers will continue to enjoy all the rights that they currently have. Over decades of existence, the IHSS program has developed a rich system of regulations and rules that serve to protect consumer rights ranging from a prohibition on forced "volunteer" care providers to language access for the limited English proficient.

> **Recommendation:** Affirm the maximum inclusion and integration principle of the IHSS program, add requirements for plan competence and include strong, specific consumer protections.

The most important consumer protection is the right to choose not to join or to opt-out of managed care for IHSS consumers who wish to maintain or develop their own provider networks rather than join a plan. The above discussion provides more details on the enrollment process, but we wanted to note here that the denial of a right to opt-out and/or institution of a lock-in period are particularly inconsistent with the *Olmstead* plan principle of self-determination, and duals' rights to freedom of choice of providers.

For those who do choose to join or remain in a plan, yet who are self-directing and receive services through the IP mode, self-determination should be preserved by making plan involvement in IHSS available a la carte, allowing self-directing consumers to design integration to make sense for their particular circumstances. Areas where a consumer may exercise choice should include, for instance: determining whether IHSS providers are involved in the consumer's care team, and the extent of that involvement; determining necessary qualifications for IHSS providers; determining necessary training for IHSS providers.

In order to avoid undermining the role that IHSS plays in implementing *Olmstead*, the legislature and the administration should take all feasible steps to ensure that the current IHSS program remain a minimum floor for benefits and consumer protections. This can be accomplished in part by:

- Keeping counties responsible for independent needs assessments, providing a benchmark for evaluating the added value of plans.
- Requiring that each plans' LTSS expenditures, as a percentage of total expenditures on duals, remain at or above the current percentage, and that community LTSS expenditures, as a percentage of total LTSS expenditures, remain at or above the current percentage.
- Incorporate the Hourly Task Guidelines, which reflect years of careful stakeholder process, in both implementing legislation and plan contracts.
- Guarantee consumers who get IHSS through managed care all of the rights (including for judicial review) they enjoy under the current system. State legislation and plan contracts should make clear that plans are responsible for complying with the Americans with Disabilities Act, and that they share in the state's liability.
- Enshrine the *Olmstead* purpose of IHSS in statute and in contracts.

Other LTSS Programs

We are particularly concerned about the proposal to completely integrate MSSP into the managed care plan's operation. The MSSP program has a long history of successfully providing intense case management services for nursing facility eligible persons so they can remain in the community. This is an infrastructure that should be preserved and built on, not destroyed in favor of a system administered by plans which have never done this type of work. The better model would be to require plans to contract with MSSP for case management of these high need individuals who are nursing facility eligible and express a preference for living in the community.

> **Recommendation:** Require plans to contract with MSSP for case management of dual eligibles who are nursing facility eligible and express a preference for living in the community.

4. SITE AND PLAN SELECTION

We doubt, for the following reasons, the proposal's claim that the Department conducted a 'rigorous selection process' to select plans that 'demonstrate a proven track record of business integrity and high quality service delivery.'

First, only one plan that responded to the Request for Solutions (RFS) did not receive an approval letter. That one plan happens to be under investigation for Medicare and Medi-Cal fraud. All plans not under investigation for fraud were approved. Two plans received approval letters even though they were the only plan to apply from a Two-Plan or GMC county (the RFS clearly required that more than one plan apply from those counties).

Second, many of the plans selected have records of poor performance in both the Medicare and Medi-Cal programs. NSCLC recently released a report summarizing the Medicare plan performance ratings and Medi-Cal CAHPS scores of the plans that were selected to participate in the four initial Demonstration counties.[4]

On the Medi-Cal side, seven of the eight plans received a global health plan rating of 1 out of 5 stars. On the Medicare side, two of the plans selected have a below average rating and have received a notice of non-compliance from the Medicare program. One of those has been marked as a low-performing plan for three consecutive years and is at risk for termination of its Medicare contract. Another plan was recently sanctioned by Medicare as a result of beneficiary access problems. Medicare continues to restrict the enrollment of dual eligibles into that plan's Part D products. All eight proposed demonstration plans were found to be low-performing on at least one composite Medicare quality measure.

[4] National Senior Citizens Law Center, "Assessing the Quality of California Dual Eligible Demonstration Health Plans," May 2012. http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Plan-Ratings-Report-May-2012.pdf

Finally, a review of the publicly available plan applications revealed that many of the plans failed to comply with the requirement in the RFS that they provide three years worth of data on all Medi-Cal and Medicare quality performance indicators. At least two of the plans failed to provide any performance data at all. We question how a plan could be approved at all if it failed to comply with the application requirements found in the RFS. We also wonder how the Department could verify the quality of these plans without reviewing quality performance results.

The proposal includes a concern that Medicare star ratings may not accurately capture the performance of plans serving dual eligibles. We note that several of the plans selected for the demonstration have average plan Medicare ratings and several plans serving dual eligibles in California and across the country have above average and excellent ratings. If the Department believes that the star rating system is not sufficient, another measure should be offered to demonstrate the high quality of plans selected to participate.

> **Recommendation:** Select only plans with strong performance records in both Medicare and Medi-Cal. Do not allow plans with below average Medicare quality ratings or plans with a recent history of sanctions in the Medicare program to participate.

Los Angeles County

Los Angeles County's size, diversity (a large number of LA County dual eligibles speak a language other than English at home) and complex publicly-funded health system make it one of the most difficult places in the country to conduct a dual eligible integration demonstration. The plans selected to participate in the county have poor performance records and currently serve a very small portion of the county's dual eligibles.

The NSCLC report indicates that Health Net's Medicare plans have a very recent history of Medicare enrollment and marketing sanctions. Due to problems providing access to prescription drugs, the plan was barred for nearly all of 2011 from enrolling any new members. While these sanctions were lifted in late 2011, the plan is still prohibited from auto-enrolling dual eligibles into its Part D benchmark plans. On the Medi-Cal side, the plan received very low scores including the second lowest score statewide on the measure of "Getting Needed Care."

According to the NSCLC report, LA Care has a below average rating from Medicare and has received notice from Medicare that it is out of compliance with the Medicare program. A plan that is rated below average three years in a row is at risk of termination of its Medicare contract. LA Care has only been below average for one year, but in previous years the plan has been too small to receive any rating at all.

Combined, Health Net (4,632) and LA Care (2,860) serve fewer than 7,500 of Los Angeles' 373,941 dual eligibles. We do not see how receiving an additional 175,000 or more enrollees each via a passive enrollment process would help either plan cure their current performance problems.

Recommendation: Select counties of a manageable size with quality, experienced plans. Do not include Los Angeles County in the demonstration. If Los Angeles County is included, prohibit the selected plans from utilizing passive enrollment.

San Diego County

While San Diego County has shown a commitment to improving care for dual eligibles over the last several years, we have concerns about several of the plans selected.

Molina is one of the lowest performing Medicare plans in the state of California. As a plan that has received a below average rating for three years in a row, it is now identified as a 'low performing plan' on the Medicare.gov website. Medicare has told 'low performing plans' that they are at risk of termination of their Medicare contract and has granted a Special Enrollment Period to all current members allowing them to leave the plan. Molina also received low ratings on the Medi-Cal side of its business.

Our concerns about Health Net's Medicare plans are summarized above. Health Net's San Diego Medi-Cal plan raises additional concerns as it is ranked lowest in the state for in Rating of Health Plan (Adult) and Getting Needed Care (Adult). It is third lowest in the state for Rating of all Health Care and fifth lowest for Shared Decision-Making (Adult).

Care 1st had an average overall Medicare ranking, but was below-average in several key areas. On the Medi-Cal side, it has a low overall rating and was among the state's lowest plans for Shared Decision-Making and Rating of All Health Care.

Community Health Group serves too small a number of dual eligibles to receive an overall Medicare rating, but received a below average ranking for several individual measures. The plan received low ratings in the Medi-Cal program.

Combined, Care 1st (2,086), Community Health Group (1,071), Health Net (2,318) and Molina (1,252) serve just 6,727 of San Diego's 75,724 dual eligibles. We do not see how receiving an additional 18,000 or more enrollees each via a passive enrollment process would help any of these plans to cure their current performance problems.

Recommendation: Move forward with the demonstration in San Diego County, but without passive enrollment. If passive enrollment is used, prohibit Molina and Health Net from receiving passive enrollments. Enrollment of members into the remaining two plans should occur over at least a two year period to ensure that the plans can handle the increased enrollment.

Orange and San Mateo Counties

The performance records of the plans in these two counties, while clearly demonstrating room for improvement, raise fewer concerns. We are concerned, however, about each plan's ability to handle the large influx of new members that a passive enrollment process would bring.

CalOptima currently provides Medicare benefits to just 13,400 of Orange County's 71,588 dual eligibles. The Health Plan of San Mateo County currently provides Medicare benefits to 7,925 of the county's 13,787 dual eligibles (the highest percentage of any plan by far).

> **Recommendation:** Move forward with the demonstration in these counties, but without passive enrollment. If passive enrollment is used, enroll members into CalOptima over a two year period to ensure that the plan can handle the increased enrollment.

5. NUMBER OF COUNTIES

Under the CCI, the Department seeks authority to enroll into the demonstration up to 750,000 dual eligibles in ten counties in 2013 and over 1 million dual eligibles in 28 counties by 2015. This reflects a significant departure from California's plan in early 2011 to enroll just 150,000 dual eligibles in up to four counties and poses significant risk to beneficiaries and the state of California.[5] The decision to expand the scope of the demonstration appears to be driven primarily by the desire to save money, as a reasonable policy rationale for the change has not been provided. We oppose the proposal to expand the demonstration beyond four counties and object to the inclusion of Los Angeles County (see more information on Los Angeles County above).

The more beneficiaries that are enrolled in the demonstration in the first year, the more difficult it will be to notify them about and assist them through the transition. Identification of sufficient numbers of providers to serve higher numbers will be a challenge as will the creation of enrollment and data management systems capacity. Implemented on too large a scale, it will be difficult to correct problems that arise.

Implementing the demonstration for more beneficiaries in more counties in 2013 also means involving more health plans. As discussed in more detail above, we do not believe that there are sufficient plans prepared to take on this complicated project at this time.

Enrolling that many dual eligibles into these new models before we know whether and how they will work also puts the state of California at risk. Despite not mentioning cost savings as a goal of the demonstration, it is obvious that the Department is making decisions primarily based on their budget impact. If savings are not realized, however, or the quality of care is not maintained or improved as imagined, the state will have few options for laying out a new course of action.

> **Recommendation:** Focus the demonstration on no more than 4 counties that have demonstrated the capacity to take on this difficult task. Wait to learn from those counties before expanding.

[5] California DHCS Response to Request for Proposal, State Demonstrations to Integrate Care for Dual Eligibles, January 28, 2011. http://www.dhcs.ca.gov/Documents/State%20Demonstrates%20to%20Integrate%20Care%20for%20Dual%20Eligibles.pdf

6. BENEFICIARY PROTECTIONS AND IMPROVEMENTS

As mentioned above, there are many important areas where consumer protections have not been fully developed and where time is running short do so. Enrollment process, care continuity rules, appeals and grievances, network adequacy rules, language and disability access rules are just a few. These protections must be detailed well in advance of implementation so that beneficiaries understand their rights, plans understand their obligations and the Department and CMS have in place mechanisms for ensuring the protections are working.

We also note that while the proposal provides the Department and Medicare savings and managed care plans new enrollment and expanded business, it includes no guarantee of any new benefits or services for dual eligibles. The care coordination it offers is already available to dual eligibles through existing Medi-Cal and Medicare managed care organizations and, for some, through home and community based services like CBAS and MSSP. Other potential benefits the proposal purports to offer - for example, dental and vision benefits the state has cut in recent years and expanded access to home and community based services - are theoretical and contingent upon financing. The proposal must guarantee that beneficiaries will get something they cannot get now.

Recommendation: Add more details on consumer protections including care continuity, appeals and grievance, ombudsman, the enrollment process, network adequacy and language and disability access rules.

Recommendation: Require the inclusion of additional benefits like dental and vision in the plan benefit packages. Create specific requirements related to the enhanced provision of home and community based services.

Comments on other elements of the proposal are provided in the comment response form attached to this letter.